

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

68218

## CERTIFICATE OF DEATH

8242

Reg. Dist. No. 105

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>				
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	Charles MARYLAND Rural - Waldorf life	STATE Maryland COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Waldorf	(If rural give location) STREET ADDRESS Berry Road			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Berry Road.					
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> Aug 2, 1956				
(First) JUANITA	(Middle) S.	(Last) BERRY	(Month) Aug	(Day) 2	(Year) 1956	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> white	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> widow	<b>8. DATE OF BIRTH</b> May 24, 1886	<b>9. AGE last birthday</b> 70 yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Home	<b>11. BIRTHPLACE</b> (State or foreign country) unk.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Don SANZIO		<b>14. MOTHER'S MAIDEN NAME</b> ELLA Hubert				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, unk.) No		<b>16. SOCIAL SECURITY NO.</b> 137036932A		<b>17. INFORMANT &amp; ADDRESS</b> Mrs Vivian B. Norris Waldorf, Md.		
<b>18. MEDICAL CERTIFICATION</b>						
<p><b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 904.0 IMMEDIATE CAUSE (A) <i>Fractured Right Hip</i> 6 mos.            ANTECEDENT CAUSE(S) DUE TO <i>Fractured Right Hip</i> 7 mos.            DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE            STATING UNDERLYING CAUSE LAST. DUE TO <i>Fracture</i> 8" 0            (C) <i>Infected Bed Sores</i> 2 mos.</p>						
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>						
<b>19a. DATE OF OPERATION</b> Dec 3, 1955		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>Fractured Right Hip</i>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Home		21c. WHERE DID INJURY OCCUR? (City or town) Rural - Berry Rd - Waldorf Co. Md.		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 1, 1955 - 9:30 AM		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall at home		
<b>22. I hereby certify that I attended the deceased from 10/1/19... 19... to 8/3/19... 19... that I last saw the deceased alive on 7/27 1956, and that death occurred at 11th, from the causes and on the date stated above.</b>						
<b>SIGNATURE</b> <i>Vivian B. Norris</i>						
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> Burial		<b>DATE THEREOF</b> 8-4-56	<b>NAME OF CEMETERY OR CREMATORIUM</b> St Peters	<b>DATE SIGNED</b> Agus 8/3/56		
<b>24. REC'D BY REGISTRAR</b> DATE AUG 5 1956		<b>REGISTRAR'S SIGNATURE</b> M. L. Monroe		<b>LOCATION (City, town, or county)</b> Waldorf, Md.		
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Hunt Funeral Home		<b>ADDRESS</b> Waldorf, Md.				

OF SECURITY TO THE UNITED STATES GOVERNMENT

CERTIFICATE OF AUTHORITY

44-42-45-5

RECEIVED IN THE  
DEPARTMENT OF STATE LIBRARY



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BUREAU X-8

AUG 5 1956

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, it may be detached from this death certificate assembly and used as a burial transit permit.

VS AISC 1-51 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****8243 CERTIFICATE OF DEATH**

08219

Reg. Dist. No. 100

**1. PLACE OF DEATH**

COUNTY Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS La Plata

Physicians Memorial Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland

COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

Bryans Road

STREET  
ADDRESS

(If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**

(First) Albert

(Middle) Marvin

(Last) Betts

**4. DATE  
OF  
DEATH** (Month) (Day) (Year)

August 10, 1956

**5. SEX**

Male

**6. COLOR OR  
RACE**

col.

**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)**

Married

**8. DATE OF BIRTH**

July 25, 1901

**9. AGE last birthday**

55

yrs.

**IF UNDER 1 YEAR**

Months

Days

**IF UNDER 24 HRS.**

Hours

Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Tenant Farmer

**10b. KIND OF BUSINESS  
OR INDUSTRY**

Farm

**11. BIRTHPLACE** (State or foreign country)

Virginia

**12. CITIZEN OF WHAT  
COUNTRY?**

USA

**13. FATHER'S NAME**

William Thomas Betts

**14. MOTHER'S MAIDEN NAME**

Mary Eliza Evans

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**  
(Yes, no, or unk.)

no (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.****17. INFORMANT & ADDRESS**

Mary Morton, Bryans Road, Md.

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

IMMEDIATE CAUSE (A)  
 ANTECEDENT CAUSE(S) DUE TO  
 DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. (B)  
 DUE TO  
 (C)

**18. MEDICAL CERTIFICATION**

*Cerebral hemorrhage* 8-10-56  
*Hypertension* ??

INTERVAL BETWEEN  
ONSET AND DEATH**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES  NO **21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour)**21e. INJURY OCCURRED****21f. HOW DID INJURY OCCUR?**M. While at work  Not while at work 

**22. I hereby certify that I attended the deceased from 8-10, 1956, to 8-10, 1956, that I last saw the deceased alive on 8-10, 1956, and that death occurred at 12 noon.** *E.G. Edelen* **DATE SIGNED** 8-10-56  
**SIGNATURE** *E.G. Edelen* **ADDRESS** (Street, city, town, state)

**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)****DATE THEREOF****NAME OF CEMETERY OR CREMATORIUM****LOCATION (City, town, or county)**

(State)

**24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE****25. FUNERAL DIRECTOR'S SIGNATURE**

ADDRESS

AUG 13 1956

Julia Poyng

Albert Funeral Home, La Plata, Md.

RECEIVED BY THE STATE OF SOUTH DAKOTA

CERTIFICATE OF DEATH

10

RECEIVED

BUREAU X.

AUG 13 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88220

Reg. Dist. No.

100

## CERTIFICATE OF DEATH

8244

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WASHINGTON PATTERSON Bowling</b>		First	Middle	Last	4. DATE OF DEATH <b>AUG 27 1956</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 FEB 1869</b>	9. AGE (In years lost birthday) yrs. <b>87</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Wallace Bowling</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Dolman</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Walter W. Bowling Nwepoort, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>age</b>		<b>Cardiac arrest</b>				INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>		
		<b>atherosclerosis</b>				<b>10 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug 17 1956</b> to <b>8-27 1956</b> that I last saw the deceased alive on <b>8-27 1956</b> , and that death occurred at <b>300 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>La Plata</b> DATE SIGNED <b>8-27-56</b>						
ACTUAL SIGNATURE <b>JM Johnson</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>E.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 30 1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Dentsville</b>		22d. LOCATION (City, town, or county) <b>DENTSVILLE MD.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt. Funeral Home</b>		24a. REC'D BY REGISTRAR <b>SEP 4 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Prof. Wills Possey</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 8245 CERTIFICATE OF DEATH

88221

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	Charles La Plata	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland	COUNTY Charles	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Physicians Memorial Hospital		STREET ADDRESS (If rural give location)	4 Jackson Rd.	
<b>3. NAME OF DECEASED (Type or Print)</b>			<b>4. DATE OF DEATH</b>		
CAROL CATHERINE CARPENTER			AUG 9 1956		
S. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 5, 1903	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nichols			14. MOTHER'S MAIDEN NAME Lillie Moon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Charles B. Carpenter Indian Head, Md.	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>					
782.4 IMMEDIATE CAUSE (A) <i>Cardiac failure</i>					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)					
10. INTERVAL BETWEEN ONSET AND DEATH 10 days					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
obesity 10 yrs.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work      Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-71, 1956, to 8-9, 1956, that I last saw the deceased alive on 8-8, 1956, and that death occurred at 7:45 A.M., from the causes and on the date stated above. SIGNATURE <i>J. Johnson</i> M.D. ADDRESS (Street, city, town, state) LAPLATA MD DATE SIGNED 8-9-56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-12-56	NAME OF CEMETERY OR CREMATORIUM Pisgah Cem (M.E.)	LOCATION (City, town, or county) Pisgah, Md. (State)	
24. REC'D BY REGISTRAR AUG 15 1956 DATE		REGISTRAR'S SIGNATURE <i>Julia Posey</i>	25. FUNERAL DIRECTOR'S SIGNATURE The Huntt Funeral Home Waldorf, Md.		

RECEIVED - MAIL ROOM - STATE GOVERNMENT OF MASSACHUSETTS

THE CERTIFICATE OF DEATH

BUREAU V.

AUG 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118222  
Reg. Dist. No. 106

1. PLACE OF DEATH a. COUNTY CHARLES Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COBB ISLAND		c. LENGTH OF STAY IN 1b 6 MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLOW HEIGHTS	
f. STREET ADDRESS 5943 28-Ave		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELVIN W.		First	Middle
4. DATE OF DEATH Oct 8 1956		Month	Day
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-8-23		9. AGE (In years birth day) 32 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Instrument Maker		10b. KIND OF BUSINESS OR INDUSTRY NAVAL REPRODUCTION	11. BIRTHPLACE (State or foreign country) Chadron Neb.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD B. CHEVILLE	
14. MOTHER'S MAIDEN NAME INEZ C. BLANKENSHIP		15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 579-20-1192	
17. INFORMANT Mrs Naomi M. CHEVILLE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO DR. ROWNIN N.C. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY LEAD CONTRIBUTING CAUSE OF DEATH	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL FROM BOAT 8-4-56	
23. MEDICAL CERTIFICATION		24. TIME OF INJURY Month, Day, Year Hour g. m. 19	
		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		27. (City or town) (County) (State)	
		28. DATE OF BURIAL, CREMATION, REMOVAL (Specify) 8-9-56	
		29. DATE THEREOF 8-9-56	
		30. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL	
		31. LOCATION (City, town, or county) SUITLAND MD	
		32. DATE AUG 8 1956	
		33. FUNERAL DIRECTOR'S SIGNATURE W. Chambers B. Wash. D.C.	
		34. ADDRESS Mr. Glynn	
		35. REC'D BY REGISTRAR	
		36. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 8 1956

BUREAU Y. S.

## 8247 CERTIFICATE OF DEATH

Reg. Dist. No. 100

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Charles La Plata (en-route)	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Cobb Island STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH 8 - 27 1956 (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-18-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electro-Matic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 54 yrs.
13. FATHER'S NAME Albert V. Denham		11. BIRTHPLACE (State or foreign country) Washington D.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		12. CITIZEN OF WHAT COUNTRY U.S.A.	
16. SOCIAL SECURITY NO. 579-40-0109		17. INFORMANT & ADDRESS Helen V. Denham, Coff. abandoned	
18. MEDICAL CERTIFICATION Ischaemic Occlusion INTERVAL BETWEEN ONSET AND DEATH 8-27-56			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... 8-27-56, to..... 8-28-56, 19....., that I last saw the deceased alive on..... 8-27-56, 19....., and that death occurred at..... 12:30 P.M., from the causes and on the date stated above. SIGNATURE <i>K. Pedersen</i> ADDRESS (Street, city, town, state) <i>La Plata Md.</i> DATE SIGNED <i>8-27-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF 8-30-56	
24. REGISTRAR'S SIGNATURE AUG 29 1956 DATE		NAME OF CEMETERY OR CREMATORIUM St. Lincoln Cem.	
REGISTRAR'S SIGNATURE <i>Julia Posey</i>		LOCATION (City, town, or county) Washington D.C. ADDRESS 222 Chambers St 517-1157 H.D.E.	
25. FUNERAL DIRECTOR'S SIGNATURE <i>L. L. Hodson</i>			

PREAU Y. S.

AUG 29 1956

LIBRARY

## INSTRUCTIONS

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

118224

8248

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	CHARLES LA PLATA	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUT ON OR STREET ADDRESS	6 DAYS		STREET ADDRESS Indian Head
Physicians Mem. Hospt		(If rural give location) Riverside 34 Carroll Dr 8-4941	
3. NAME OF DECEASED (First) (Middle)		4. DATE OF DEATH	
HENRY W. GARDNER		AUG 4 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
M	WHITE		DEC 22, 1885
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).		10b. KIND OF BUSINESS OR INDUSTRY	
Tool Maker		Rhode Island	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry J. Gardner		Abby Pickerton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.	
No		1035-10-7919	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
HOSPITAL Records		Cardio Renal Disease Hyperthyroidism Osteo Arthritis General None	
IMMEDIATE CAUSE  ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO  (B) (C)	
		INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15 - 19 1956</u> to <u>Aug 4 1956</u> , 19....., that I last saw the deceased alive on <u>Aug 4 1956</u> , and that death occurred at <u>La Plata</u> , from the causes and on the date stated above. SIGNATURE <u>James E. Gardner M.D.</u> DATE SIGNED <u>Aug 4 1956</u>		ADDRESS (Street, city, town, state)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		NAME OF CEMETERY OR CREMATORIUM	
24. REC'D BY REGISTRAR DATE <u>Aug 7 1956</u>		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
Julia F. Posey		W.W. Chambers Co 517-110 ST S.E. Jim Robinson 9352	

ALAZAU Y. A.

Aug 7 1956

100% V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118225

8249

## CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAPALIS</i>		c. LENGTH OF STAY IN 1b RURAL AND GIVE NEAREST TOWN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Charles</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Home Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>FRANCIS J.</i>		First	Middle	4. DATE OF DEATH <i>HIGDON</i>	Month <i>Aug</i>	Day <i>10</i>	Year <i>1917</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-27-1873</i>	9. AGE (in years last birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. MIN. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naval Powder Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Charles County</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas Higdon</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Franklin</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>none</i>		17. INFORMANT <i>Wilson W. Wright Accokeek, Md.</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Collyposis</i>		DUE TO <i>157X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 mon.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Cardiac - of pancreas</i>		DUE TO <i>(b)</i> <i>DUE TO</i> <i>(c)</i>		<i>1 year</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>—</i>	
ACTUAL SIGNATURE <i>A. O. Wooddy</i>		DATE SIGNED <i>—</i>							
PHYSICIAN'S NAME (Type) <i>A. O. Wooddy MD</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Marbury Cem.</i>		22d. LOCATION (City, town, or county) <i>Marbury, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home Waldorf, Md.</i>		ADDRESS <i>—</i>						24a. REC'D. BY REGISTRAR DATE <i>Aug 31 1956</i>	
								24b. REGISTRAR'S SIGNATURE <i>Julia Poage</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

Aug 21 1956

REGULATED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8250

## CERTIFICATE OF DEATH

118226

100

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL, OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN STREET ADDRESS
Charles La Plata	MD	Maryland Charles Hilltop	(Rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>By Memorial Hosp</i>			
<b>3. NAME OF DECEASED (Type or Print)</b> William		<b>4. DATE OF DEATH</b> 8 30 56	
SEX <input checked="" type="checkbox"/>	6. COLOR OR RACE <input checked="" type="checkbox"/>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify <i>Married</i>	8. DATE OF BIRTH <i>May 15 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Farming Md</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	9. AGE last birthday 63 yrs.
13. FATHER'S NAME <i>William Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Ellen Mason</i>	12. CITIZEN OF WHAT COUNTRY? <i>Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT & ADDRESS <i>Mac Wellitt Elizton Md</i>	18. MEDICAL CERTIFICATION <i>Cerebral hemorrhage Septic sepsis</i>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH <i>8-8-56 7-1</i>	
IMMEDIATE CAUSE <input type="checkbox"/> (A)	ANTECEDENT CAUSE(S) DUE TO <input type="checkbox"/> (B)	GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <input type="checkbox"/> (C)	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8-8-56</i> , to <i>8-30-56</i> , that I last saw the deceased alive on <i>8-29-56</i> , and that death occurred at <i>1/2 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>J. E. Edelma, M.D.</i>		ADDRESS (Street, City, Town, State) <i>Levittown Md</i> DATE SIGNED <i>Levittown Jul 8-30-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Sept 1, 1956</i>	NAME OF CEMETERY OR CREMATORIUM <i>J. J. Duvalon</i>	LOCATION (City, town or county) (State) <i>Brookside Md</i>
24. RECEIVED BY REGISTRAR DATE <i>SEP 5 1956</i>	RECEIVER'S SIGNATURE <i>Mrs. J. Wells Powers</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Hunt Funeral Home Brookside</i>	

SUREAU

CEP 3122

ALLEGRA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8251

## CERTIFICATE OF DEATH

118227  
Reg. Dist. No. 282

100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>	
3. NAME OF DECEASED (Type or print) <b>PATTIE</b>		First <b>ELIZABETH</b>	Middle <b>KERSHAW</b>
4. DATE OF DEATH Month <b>AUGUST</b>		5. DATE OF DEATH Year <b>27 1956</b>	6. DATE OF BIRTH Month <b>8/18/1869</b>
S. SEX <b>FEMALE</b>	7. COLOR OR RACE <b>WHITE</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. AGE (In years last birthday) <b>87 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (State or Foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JEREMIAH DUDLEY</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE ALVEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>LUCILLE K. NORRIS - LEONARDTOWN, Md.</b>
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1956</i> to <i>Aug 27, 1956</i> , that I last saw the deceased alive on <i>Aug 19, 1956</i> , and that death occurred at <i>9:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Roy Guyther</i> M.D. ADDRESS (Street, city or town, state) <i>Mechanicsville</i> DATE SIGNED <i>8/27/56</i>			
PHYSICIAN'S NAME (Type) <b>J. ROY GUYHER, M.D.</b>		MECHANICSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/29/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>OLDFIELD CEMETERY</b>	22d. LOCATION (City, town, or county) <b>HUGHESVILLE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Robinson</i>	ADDRESS <b>LEONARDTOWN, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>8/28/56</b>	24b. REGISTRAR'S SIGNATURE <i>Alan D. Howard Julia Hayes</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 29 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8252

118228<sup>100</sup>

Reg. Dist. No. 282

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>CHARLES CO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>ST MARYS</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HUGHESVILLE</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>U.S.NAS Potomac River</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hospital #5</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DONALD EUGENE MARTIN</i>		4. DATE OF DEATH <i>8 3 56</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-29-33</i>	9. AGE (in years last birthday) <i>22 yrs.</i>	10. IF UNDER 16 YEARS Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. NAVY</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>CALIFORNIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JOHN EDWIN MARTIN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES ✓ 8-51 to 85-8</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>U.S. NAVY Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		CUSHED Chest		INTERVAL BETWEEN ONSET AND DEATH <i>8-5-56</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
(c)		DUE TO		Auto accident - driver		8-5-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Driver of automobile which left highway and overturned</i>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>STREET</i>		20d. (City or town) <i>HUGHESVILLE, Charles, Md.</i>	
20e. TIME OF INJURY Month, Day, Year Hour o. m. <i>12:15 AM Aug 5 1956</i>		20f. (County) <i>Charles</i>		20g. (State) <i>M.D.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>8-6-56</i>	
EXAMINER'S NAME (Type) <i>E. J. Edelen</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		22b. DATE THEREOF <i>8/7/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Leonardtown, Md.</i>		22d. LOCATION (City, town, or county) <i>Kansas City, Missouri</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Johnson</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>8/7/56</i>		24b. REGISTRAR'S SIGNATURE <i>George L. Powers /3 Julia Banks</i>	

BUREAU V. S.  
RECEIVED

AUG 8 1966

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118229

8253

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Charles Co</i>		a. STATE <i>Md</i>	b. COUNTY <i>Charles</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcom</i>		c. LENGTH OF STAY IN 1b <i>Welcom</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EDNA</i>		First <i>M</i>	Middle <i>Matthew</i>
4. DATE OF DEATH		Month <i>8</i>	Day <i>14</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 14 1908</i>		9. AGE (In years lost birthday) <i>55 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>A W</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>	
10c. BIRTHPLACE (State or foreign country) <i>md</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Hall</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Duckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Brooks Matthews Welcom</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Cerebro Vasculair Accident</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>271X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-11-56</i>	
(b) DUE TO <i>Nephritis</i>			
(c) DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Belltop</i> (County) <i>md.</i> (State)	
21. I certify that I attended the deceased from _____, <i>1954 to 8-14</i> , 1956, that I last saw the deceased alive on _____, <i>19</i> , and that death occurred at _____, <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/18/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St Ignatius</i>		22d. LOCATION (City, town, or county) <i>Belltop</i> (State) <i>md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rechardine La Plata</i>		24a. REC'D BY REGISTRAR DATE <i>8/16/56</i> 24b. REGISTRAR'S SIGNATURE <i>Jules H. Barry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10231

Reg. Dist. No. 100

10830

TO **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata, Md.</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians' Memorial Hospital</b>		d. STREET ADDRESS <b>17 N St., S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Richard</b>	Middle <b></b>	Last <b>Mitchell</b>
4. DATE OF DEATH	Month <b>8</b>	Day <b>22</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1902</b>
9. AGE (In years last birthday) <b>53 yrs.</b>	10. IF UNDER 1YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
10c. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b></b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Fractured Cervical Vertebrae -Cord Severance</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Automobile Accident</b>  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto involved in accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>8-19-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b> 20f. (City or town) <b>Hughesville, Charles, Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE 		DATE SIGNED <b></b>	
EXAMINER'S NAME (Type) <b>E. J. Edelen, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>		22b. DATE THEREOF <b>8-27-56</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Broadlawn</b>		22d. LOCATION (City, town, or county) <b>Stash. DC</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazee's Funeral Home</b>		ADDRESS <b>389-R St Ag</b>	
24a. REC'D BY REGISTRAR <b>Oct. 24, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Selma Osega</b>	

BUREAU V.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8257

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68233

Reg. Dist. No. 100

1 DENTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corpora's limits, write RURAL and give nearest town) <i>LA PLATA</i>	c. LENGTH OF STAY IN 1b	b. COUNTY <i>47X</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Wmn Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mitchell</i>	Middle <i>RICHARD</i>	Last <i>S</i>
4. DATE OF DEATH <i>Jan 15, 1902</i>	Month <i>Jan</i>	Day <i>22</i>	Year <i>1936</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 15, 1902</i>
9. AGE (In years last birthday) <i>58</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Concrete worker</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>N.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>	Address <i>Ethel M Mitchell Washington DC</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Thrac. Conv. Vert &amp; Cord Services</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) <i>Auto accident</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Re</i>		
20c. TIME OF INJURY Hour a. m. p. m. <i>8 19 1936</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, shop, office, bldg., etc.) <i>Re</i>	20f. (City or town) (County) (State) <i>Stephens Ches Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>F. J. Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>F. J. Edelen</i>	DATE SIGNED <i>8-23-36</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/27/56</i>	22c. NAME OF CEMETERY OR CREATORY <i>Woodlawn</i>	22d. LOCATION (City, town, or county) (State) <i>Washington DC</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franklin Lewis Herk La plata</i>	ADDRESS <i>Franklin Lewis Herk La plata</i>	24a. REC'D BY REGISTRAR DATE <i>8/27/56</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Hayes</i>

RECEIVED

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RECEIVED

TO **PUBLIC DIRECTOR**: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 20 Film 6702 9-8254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 118230

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS E</b>		d. STREET ADDRESS <b># 8 Condem Rd.</b>	
3. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 4, 1950</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Charles Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond E Pearson</b>		14. MOTHER'S MAIDEN NAME <b>Grace E. Weaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>[Redacted]</b>	
17. INFORMANT <b>Raymond Pearson Indian Head Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>ELECTROCUTION</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>+0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>[Redacted]</b> DUE TO (c) <b>[Redacted]</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Electrocuted on home-made fence</b>			
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Electrocuted on home-made fence</b>	
20c. TIME OF INJURY Month, Day, Year Hour: 7:30 a.m. 8/11/56 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1st fl (Home)</b>		20f. (City or town) <b>Indian</b>	
		(County) <b>Charles</b>	
		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>	DATE SIGNED <b>8-12-56</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/14/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St Pauls Cemetery</b>	22d. LOCATION (City, town, or county) <b>Waldorf</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard Inc LaPlace Md</b>	ADDRESS <b>[Redacted]</b>	24a. REC'D BY REGISTRAR <b>Julia W. Pasay</b>	24b. REGISTRAR'S SIGNATURE <b>Julia W. Pasay</b>
VS. A15MS(S) SM 9/55	DATE <b>8/16/56</b>		

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BUREAU Y.

AUG 20 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118231

Reg. Dist. No.

105

**1**  
**DEPUTY MEDICAL EXAMINER:** This certificate shall be executed within 4 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Walter	Middle Peterson	Last Peterson	4. DATE OF DEATH 8	Month 30	Day 19	Year 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1892	9. AGE (in years less birthday 64 yrs.)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (State or foreign country) Minnes			
13. FATHER'S NAME Kraute Peterson				14. MOTHER'S MAIDEN NAME Emma Yener					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>					
17. INFORMANT <i>none Ernest H. Peterson Edna and</i>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) DUE TO (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) DUE TO (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) 									

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08232

## 8256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

105

**NOTARIZED** This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in a padded envelope, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived? If institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Vera</i>		First <i>Mae</i>	Middle <i>Proctor</i>
4. DATE OF DEATH Last <i>8</i>	Month <i>31</i>	Day <i>Year 1956</i>	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>5-18-55</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Lester Proctor</i>		14. MOTHER'S MARRIED NAME <i>Catherine Queen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Lester Proctor Waldorf Md</i>		(Address)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>571.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8-30-31-34</i>	
DUE TO <i>Inf. Diarrhea</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Waldorf</i>
20f. (City or town) <i>Waldorf</i>		(County) <i>Charles</i>	
(State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. E. ELEN</i>		DATE SIGNED <i>8-31-56</i>	
EXAMINER'S NAME (Type) <i>E. J. E. ELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> BREVET MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 1, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peter's</i>		22d. LOCATION (City, town, or county) <i>Waldorf</i>	
(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The funeral director here Waldfuneral</i>		ADDRESS <i>Waldfuneral</i>	
24. (CDP) REGISTERED DATE		24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>	

BUREAU

SEP 5 1956

WILSONVILLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8258

## CERTIFICATE OF DEATH

118234 as  
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>		c. LENGTH OF STAY IN 1b <b>11 yrs.</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <b>RIRAK</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LUCY</b>	Middle <b>ELMORE</b>	Last <b>RIDGELL</b>
4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>22</b>	Year <b>1956</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 19, 1874</b>
9. AGE (In years less birthday) <b>82</b> yrs	10. IF UNDER 1 YEAR Months <b>82</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>AUSTIN RIDGELL</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN R. HAMMETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Mrs. RUTH BRAGG - HUGHESVILLE, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Carcinoma (Basal cell) Face 10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1, 1956</b> to <b>Aug 22, 1956</b> that I last saw the deceased alive on <b>Aug 22, 1956</b> and that death accrued at <b>405 Main St., Mechanicsville, Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, State) <b>Mechanicsville, Md.</b> DATE SIGNED <b>8/23/56</b>			
ACTUAL SIGNATURE <i>J. Roy Guyther</i>	PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER, M.D.</b>	MECHANICSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/25/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>ST. MICHAELS CEMETERY</b>	22d. LOCATION (City, town, or county) <b>RIDGE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. B. Robinson</i>	ADDRESS <b>LEONARDTOWN, Md.</b>	24a. REC'D BY REGISTRAR <b>8/28/56</b>	24b. REGISTRAR'S SIGNATURE <i>Glenn O. Howard</i> <i>Julia Posey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

AUG 29 1956

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 100 118235
Items 3, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1410, 1411, 1412, 1413, 1414, 1415, 1										

8 AM 2007

Aug 7 2007

MAPLE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

105  
08236  
Reg. Dist. No.

8260

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b Unk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>Robert</i>	Middle <i>Smith</i>	Last <i>Swann</i>	DATE DEATH Month 8	Day 17	Year 1957
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-1872	9. AGE (In years at death) <b>84</b> yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 MINS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>St. Mary's County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Swann</b>				14. MOTHER'S MAIDEN NAME <b>Georgeanna Mattingly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Robert P. Bowling</b>		Address <b>Wicomico, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>gen fort Sclerosis</b> ONSET AND DEATH (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8-17-52							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edele</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		DATE SIGNED <i>8-18-52</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Rest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>La Plata, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>Hunt 21 1956</b>	
						24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

BUREAU V. S

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8261

## CERTIFICATE OF DEATH

108237  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William (Willie)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) La Plata, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Madison I. Thomas				14. MOTHER'S MAIDEN NAME Theresa Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT William A. Thomas		3054 Vista St. N.E. Washington, D.C. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cancer of Stomach				INTERVAL BETWEEN ONSET AND DEATH 1954		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)						
{		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from _____, 19_____, pronounced dead, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. J. Edelen, M.D.</i>		ADDRESS (Street, city or town, state) La Plata, Maryland						
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.		DATE SIGNED 8-11-56						
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-11-56		22b. DATE THEREOF 8-11-56		22c. NAME OF CEMETERY OR CREMATORIAL St Joseph		22d. LOCATION (City, town, or county) Pawpaw		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Director</i>		ADDRESS 1712-12th St		24a. REC'D. BY REGISTRAR Date 8/15/56		24b. REGISTRAR'S SIGNATURE Quincy H. Rosey		

HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-tranit permit. Then please remove ~~burial~~ papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

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REGISTRATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 4 FilmG202 9-1-56 et CERTIFICATE OF DEATH											
118238 Reg. Dist. No. 705											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b <u>Rural</u> UNK				<b>2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)</b> a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> <u>Rural</u>							
<b>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION</b> <u>none</u>				<b>d. STREET ADDRESS</b> <u></u>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED (Type or print)</b> <u>GRACE</u>		First <u>JOHANA</u> Middle <u>ULLMANN</u>		Last <u></u> <b>4. DATE OF DEATH</b> <u>August</u>		Month <u>22,</u> Day <u>1956</u>					
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-13-1888</u>		<b>9. AGE (In years from birthday)</b> <u>68</u> yrs. <b>IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/>		<b>Months</b> <u></u> <b>Days</b> <u></u> <b>Hours</b> <u></u> <b>Min.</b> <u></u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>			<b>11. BIRTHPLACE (State or foreign country)</b> <u>Charles County, Md.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>Anton Winkle</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Adams</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</b> <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>none</u>			<b>17. INFORMANT</b> <u>Mrs Barbara Duffy</u>			<b>Address</b> <u>Waldorf, Md.</u>		
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.1</u> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <u>Ventricular Fibrillation</u> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>few minutes</u>											
<b>(b)</b> <u>myocardial Infarction</u> <b>DUE TO</b> <u>atherosclerosis</u> <b>1 Day</b> <u>yes</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <u>6 - 20, 1956, to 6 - 22, 1956</u>			<b>20f. (City or town) (County) (State)</b> <u>Berwyn, Md.</u>		
<b>21. I certify that I attended the deceased from</b> <u>6 - 20</u> , 1956, <b>to</b> <u>6 - 22</u> , 1956, <b>that I last saw the deceased alive on</b> <u>6 - 22</u> , 1956, <b>and that death occurred at</b> <u>7:00 P.M.</u> , from the causes and on the date stated above.											
<b>ADDRESS (Street, city or town, state)</b> <u>Berwyn, Md.</u> <b>DATE SIGNED</b> <u>8/27/56</u>											
<b>ACTUAL SIGNATURE</b> <u>Richard H. Dobson</u> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <u>Richard H. Dobson</u> <b>Berwyn, Md.</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>8-25-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <u>St Joseph's Cem.</u>				<b>22d. LOCATION (City, town, or county) (State)</b> <u>Pomfret, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Huntt Funeral Home Waldorf, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>8/27/56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>M. L. Monroe</u>					

## CERTIFICATE OF DEATH

BUREAU V. S.

1956

RECEIVED

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**8263 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

88239

Reg. Dist. No.

106

Item 18: G202 9-5-56

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>		c. LENGTH OF STAY IN 1b <b>Charles</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANCIS W. WEDDING</b>		First	Middle
4. DATE OF DEATH	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-2-32</b>
9. AGE (in years last birthday) <b>24</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Repair</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Wedding</b>		14. MOTHER'S MAIDEN NAME <b>Maude Wynn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>REDOX Korea 217 28 8725</b>	
17. INFORMANT		Address <b>Joseph Wedding Indian Head, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC BRONCHITIS</b> DUE TO <b>EARLY BRONCHO PNEUMONIA</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>DUE TO FATTY INFILTRATION OF LIVER</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt</i>		DATE SIGNED <b>8/8/56</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Rest</b>
22d. LOCATION (City, town, or county) <b>La Plata, Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 15 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Mrs. Oley Price</b>

